BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

MAIL TO:
Blue Cross and Blue Shield of Florida
Spending Account Administration
P.O. Box 45132
Jacksonville, FL 32232-5132
(800) 753-4681

Health Expense Reimbursement Request Form

For Health Care Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs)

PLEASE PRINT AND COMPLETE THIS FORM IN ITS ENTIRETY. INCOMPLETE FORMS WILL BE RETURNED.

Complete the information below for out of pocket Health Care Expenses incurred by you and your eligible dependents. Eligible dependents are defined by your employer and must meet the definition of dependent as defined by the IRS for tax reporting purposes. You **must** provide an Explanation of Benefits from your Health Plan, if applicable, indicating the amount of the expense you are obligated to pay **or** a written statement, bill or receipt from an independent third party, such as an insurance company, doctor or other health care provider, indicating the date and type of medical expense that has been incurred and the amount of such expense (canceled checks will not be accepted). Only list the amounts you have to pay, (your out-of-pocket expense), after insurance, if applicable, pays its share. Please sign and date the form, then send it along with your proof of expense documentation. ***Balance forward/due or generic "cash receipts" are not acceptable.***

Employee's Name: (Last Name, First Name, Middle Initial)	**Social Security Number:**
Employer's Name:	
Specify which account(s) you participate in: ❑ Health Care FSA ❑ HRA ❑ Both	
Type of Health Plan(s). Check all that apply: ❑ PPO Health ❑ HMO Health ❑ Pharmacy ❑ Dental ❑ Vision ❑ None ❑ Other: Please specify_____ *Note: If unsure, you may enclose a copy of your ID card(s).*	

Dependent Information

Are any of your dependents college students under age 25? ❑ Yes ❑ No
Does the dependent(s) you are claiming live in your household? ❑ Yes ❑ No
Do you provide more than one-half of the support for the dependent(s) during the year? ❑ Yes ❑ No

Reimbursement For Health Care Expenses

Patient / Dependent's First & Last Name	Birth Date	Relationship To Employee	Date of Service*	Out-of-Pocket Amount	Type of Service	Name of Service Provider	BCBSF Use Only
Example: Pat Roe	**10/3/55**	**Self**	**4/9/02**	**$ 15.00**	**Doctor Visit**	**Dr. John Smith**	
				$			
				$			
				$			
				$			
				$			

*Service must be totally rendered and completed before payment on any part can be made.

TOTAL **$**

Employee Signature Required Below

I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made.

I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application.

Employee Signature: _____ **Day Phone #:** _____ **Date:** _____

FOR BCBSF USE ONLY

Processor's Name: _____ Request ID: _____ Date Processed: _____